Michael Bazel, MD, QME, Medical Director October 6, 2010
Bell Medical Center

If DWC decides to go ahead and implement this new RFA form, it should make clear what "completed" form means. For instance, Claims Administrator Information is not always known, particularly in the beginning of treatment. Sometimes, the only information given to us by the employer is insurance information. Some employers bring their injured workers without insurance information, which we get later. Therefore, making those items "mandatory" will delay care.

Also, "Only a single treatment request can be made on this form" is unclear. For instance, if the patient is given 3 different medications and ordered 3 x-rays and needs to start physical therapy, that translates into 7 forms. This is too burdensome for the physician and the reviewer. I believe, if the form accompanies a report with a request for multiple treatment, there should be a single form.

John T. Trevathan, R.N., UR Manager/MedReview, Inc. October 5, 2010
For AdminSure, Inc.

With regards to the RFA, it may be advantageous to all parties if an additional line and checkbox were added above or below the "…imminent and serious threat…" statement that indicates if the RFA is one in a series of submissions.

Examples:

This request for authorization is _____ of _____ requests submitted with the PR-2 or narrative report dated _____.

This request for authorization is __2__ of __3__ requests submitted with the PR-2 or narrative report dated __10/05/10__.

Inclusion may help to recognize fax transmittal errors sooner rather than later, enabling the claims administrator or U.R. personnel to immediately request a re-fax of the missing RFA's. This would also give the office personnel one last chance to double-check that the correct supportive report is being supplied for review.

Michael Bazel, MD, QME, Medical Director — October 4, 2010
Bell Medical Center

"Retrospective review" means utilization review conducted after medical services have been provided that do not fall within the utilization review plan's 'prior authorization' arrangement and for which approval has not already been given.

I believe this definition is vague. What is this *the utilization review plan's 'prior authorization' arrangement* ? Does it mean if the carrier decides not to have Prior authorization requirement, they can conduct review at any time retroactively? Of course there are situations when *"Retrospective review"* is applicable. For instance, in ER or when Pre-authorization request was not submitted.

I think adding a short statement "when prior authorization request was not submitted" to the definition would be helpful.

What if the carrier does not have *'prior authorization' arrangement* or if their *arrangement* includes a clause allowing going *Retrospective* route only? I think you should require all the carriers to have Prior Authorization Plan in compliance with LC 4610 or your regs.

Joe Martinez, CBO Director — September 30, 2010
Concentra, Inc.

As Stakeholder in the process (we are Provider's) we first appreciate and thank the DWC for allowing us to participate in this process and the opportunity to be heard. Below is a brief statement with respect to the Revised Draft on the new Proposed UR Regulations.

When we first looked at the new UR regulations back in March 2010 and reviewed this new "Request for Authorization Form" or RFA our concerns then and now are how would we as Providers create this form in our respective computer systems (implement operationally) and attach this new form to our PR2 and Doctor's First Report of Injury forms. Initially we were not as concerned because the DWC had also proposed an increase on PR2 reimbursement from $11.69 to $37.98 per report. But since the DWC realized this was not possible this new "RFA" form will in our opinion pose significant operational and financial burdens on providers. Should the DWC proceed with implementation of these new UR Regulations and "RFA" form we respectfully request a 12 month period of time to allow provider's time to eliminate use of old forms and time to phase in these new form(s). This time period will be needed so that provider's can do system programming.

So unless providers get a significant bump in the overall fee schedule this "RFA" form is problematic as stated.

Jerrold Garrard September 29, 2010
GSG Associates

9792.6

** In evaluating our comments on Definitions U and Z, please remember the complaint of GSG, other UROs and TPAs at the stakeholder meeting was not about Requests that had *SOME* medical records, but requests that had *NO* medical records. As a URO, we are trying to save our clients' (employers, Insurers, TPAs) money because we don't think they should be charged for a physician advisor's intervention (for a Deny LOI) when the requesting provider does not send in medical reports to support their request. With a simple redefinition of a complete RFA, we believe we could eliminate nearly 10% of our physician advisor expenses for our clients.

In return, rather than just sending the RFA back, we are still willing to send a request for information to the provider specifically telling them that a review cannot be performed without the appropriate medical record.

> We think it is very reasonable that if the RFA states the request "**Must be accompanied by a medical report substantiating the requested treatment: the Doctor's First Report of Occupational Injury or Illness (Form DLSR 5021), a Treating Physician's Progress Report (DWC Form PR-2), or a narrative report.** " then the RFA should be defined as complete only if one of these reports is present.

Definition U – needs to be expanded to define "Completed" not only that all mandatory fields have been completed, but that the appropriate medical records are included ALSO.

Definition Z – the UR process should start "when the COMPLETE DWC form RFA is first received." If the form RFA states that the claims admin can send back an incomplete RFA and the timeframes do not start unless the form is complete, then this definition should be consistent.

9792.9 (c)(2) – gives a non-physician reviewer the ability to say that an RFA is incomplete – but the above comments need to be addressed. (This could be good news if we now would not have to incur the expense of a Physician Advisor to Deny for LOI when the request includes no medical records.) We agree that this must still be done within 5 business days from initial receipt, but a clinical determination does not have to be made.

9792.9 (g) – related to Denial for LOI, shouldn't there be language that if a Claims Admin, URO agent, etc sends the requestor back their incomplete RFA, that if the requestor does not complete the RFA, a clinical decision will not be rendered and therefore the treatment is NOT authorized.

9792.7 (a) (on submitting an annual letter that our UR plan has not changed) WHY? If we are already required to submit our plan when changes are made, why do we have to submit a

letter/statement saying no changes have been made. This only ADDS EXPENSE for TPAs, Employers and UROs as well as for the DWC which must process the letters. What does this accomplish?

On the RFA – language should be added that the form is also deemed incomplete unless **accompanied by a medical report substantiating the requested treatment: the Doctor's First Report of Occupational Injury or Illness (Form DLSR 5021), a Treating Physician's Progress Report (DWC Form PR-2), or a narrative report.** and it will/ may be returned without review.

Ron Nassif, RN, BSN, CCM, COHN-s, Director, Medical Management September 29, 2010
Paladin Managed Care Services

Letter Templates are a MUST so that everyone is consistent with the required verbiage the DWC Medical Unit will Audit against.

Reina Archuleta, CPC September 27, 2010
Southland Spine and Rehabilitation Medical Center

My name is Reina Archuleta, CPC. I work for Southland Spine and Rehabilitation Medical Center, a multi-specialty medical group.

I believe that we would see a reduction in lien litigation if there was a provision in the U.R. regulations in the event of "non-response" from the carrier.

Back in 2000-01, there was verbiage in the Title 8 CCR 9792.6 that specifically stated something to the effect that "if carrier failed to respond within seven days to a request for authorization, it shall be deemed as approval".

Issue: The OMFS states that some services "require pre-authorization" such as Functional Capacity Evaluation (97670) and work conditioning (97545). The provider diligently follows the U.R. guidelines per L.C. 4610 and submits a request for pre-auth. Unfortunately, in many

instances, the carrier does not respond to the request for authorization. They later deny payment because the services required pre-authorization and since no authorization was given, the carrier believes no payment is due. We argue that no response was received so they forfeited their rights by ignoring that request.

In view of the above scenario, we are currently litigating many cases particularly against SCIF because they had failed to respond to auth requests and are using this "tactic" to deny payment. In essence, nothing in the U.R. 9792.6 address what happens if the carrier simple does not responds. Our argument is: We sought authorization, we sent them a letter advising them that no response was received within the allotted time frame and therefore, we were proceeding with treatment as prescribed by the PTP.

I believe the legislation is not clear. There are fines established for non-compliance but these do nothing to settle the provider's lien for services rendered. If this verbiage was added to the U.R. timelines; (5 day/ 14 day), I believe we would see an increase in the compliance ratio and a decrease litigation. I just completed a five-day Lien Trial where the issue was OMFS and the carrier denied payment for work conditioning because no pre-authorization was obtained (as defined in the OMFS) even though we requested pre-authorization on several occasions to no avail.

Please consider amending the U.R. regulations to address the above situation.

Eleni Apostolakis, Esq.
CompuLaw LLC

September 27, 2010

The proposed revisions to 8 CCR 9792.9(c)(3) state: "Prospective or concurrent decisions to approve, modify, delay, or deny a request for authorization shall be made in a timely fashion that is appropriate for the nature for the injured worker's condition, not to exceed five (5) business days from the date of receipt of the completed DWC Form RFA, but in no event more than 14 calendar days from initial receipt of the complete DWC Form RFA."

The above proposed changes are ambiguous as they do not specify when the 5-business day deadline applies and when the 14-day deadline applies.

The proposed changes to DWC Form RFA state that "[a] decision on the requested medical treatment must be made within five (5) working days from receipt of a complete and supported request for authorization, or 14 calendar days <u>with a timely request for information necessary to render a decision</u>." [Emphasis added.]

We suggest that if DWC Form RFA is revised per the proposed changes, 8 CCR 9792.9(c)(3) should also be revised accordingly to clarify that the 14-day deadline applies only when there has been a timely request for information necessary to render a decision.

Phil Vermeulen September 27, 2010
Advocate for AMC/AIMS

On behalf of Allied Managed Care (AMC) and Acclamation Insurance Management Services (AIMS), I would like to congratulate DWC for the excellent job with your re-write of the Utilization Review Regulations. My clients believe that the proposed revisions make them significantly more "user friendly" and are also very clear and concise. For these reasons we would like to congratulate you on a job well done and will be happy to offer our support to ensure they are adopted.

Michael Bazel, MD September 24, 2010
Bell Community Medical Group

I believe this new form DWC Form RFA is unnecessary and will make the process much more paper-intensive. Workers Comp system is already full of bureaucracy. This is just another piece of paper to add to the chart.

The present requirement of indicating authorization request in the front of the narrative report and checking off the PR-2 is sufficient to indicate that the treatment is necessary. Adding another piece of paper to say that enclosed report contains authorization request is unnecessary. Particularly, inserting a separate page for each treatment requested serves no practical purpose. For instance, when the patient needs MRI of LS-spine, Rt shoulder, and Lt knee in addition to physical therapy and chiropractic treatment, does it mean that there will be 5 MORE pages inserted in the package with the same statement saying that there is a request for authorization in report? I suggest, if you still insist on this form, to make it optional.

The other concerns I have is with the wording of 9792.9:

~~(3)(b)(1)~~ Prospective or concurrent decisions to approve, modify, delay, or deny a request for authorization shall be made in a timely fashion that is appropriate for the nature of the injured worker's condition, not to exceed five (5) ~~working~~ business days from the date of receipt of the ~~written request for authorization~~ completed DWC Form RFA, but in no event more than 14 calendar days from initial receipt of the complete DWC Form RFA.

It is not clear whether the maximum time is 5 days or 14 days from the receipt of the request. Please note, LC 4610 (g)(1) states:

> Prospective or concurrent decisions shall be made in a timely fashion that is appropriate for the nature of the employee's condition, not to exceed five working days from the receipt of the information reasonably necessary to make the determination, but in no event more than 14 days from the date of the medical treatment recommendation by the physician. In cases where the review is retrospective, the decision shall be communicated to the individual who received services, or to the individual's designee, within 30 days of receipt of information that is reasonably necessary to make this determination.

This means that 14 days apply to the date of the request and has nothing to do with the date of the receipt of the request. I suggest to just keep the language of the LC 4610 (g)(1).

(5) Retrospective decisions to approve modify, delay, or deny a request for authorization shall be made within 30 days of receipt of the medical information that is reasonably necessary to make this determination.

What is retrospective review? Does it allow the carrier to deny treatment after it has already been completed? As a matter of fact, a number of carriers have been trying to avoid timely response by instead employing this retrospective review. There should be specific rules established when retrospective review is appropriate.

(2) In the case of a dispute regarding a request for spinal surgery, a clear statement advising the injured employee that even when the recommended surgery is denied or modified in the utilization review process, the claims administrator may initiate the spinal surgery second opinion process under Labor Code section 4062(b) by filing a DWC Form 233 (Objection to Treating Physician's Recommendation for Spinal Surgery) within 10 calendar days of receipt of the DWC Form RFA.

As I understand, according to Cervantes case, the second opinion is not an option but is required if the carrier wishes to deny spine surgery.

Gary Brazina, M.D. FACS
Diagnostic & Intervention Spine and Sport Center

September 24, 2010

My greatest concerns appear on pg.12 Paragraph 1. This appears an attempt to circumvent a true "peer to peer" consultation where a reviewer need not be a specialist in the area of the medical treatment requested on that they be "competent to evaluate" the proposed treatment and that the reviewer's expertise be in the "scope of their practice".

This appears to allow chiropractors, for example, to be reviewers for orthopaedic surgical or neurosurgeon's decisions since it "backs are in the scope of their practice", yet they are clearly **not** peers nor do they understand the ramifications of surgical decisions.

Similarly, an Internist or PMR specialist could opine and not authorize surgery to a shoulder or knee even though they are not operative surgeons because the knee and shoulder are "in the scope of medical practice"

Medical sub specialization has advanced to such a degree that the "peer to peer" needs to remain intact because of the rapid changes treatment options and the need to thoroughly be acquainted with the risks and benefits of different treatment algorithms.

Johnella Shackelford September 24, 2010
Injured Worker

I tried to enter the forum but it appears that an email comment must be sent instead. If there is a way to post on the forum, please add my comment and/or send me directions as to how to use the forum. Thanks.

I am an injured worker who has had great difficulty getting medical treatment. My doctors are totally impacted because they must send numerous requests for authorization for treatment with no response or a denial or modification by the claims administrator. I have had to go to court many times (three, four or more months after the request) to receive treatment with proof that a proper request was made with an improper denial or modification or no response at all. Even though penalties for unreasonable delay of medical treatment have been properly requested in court-no penalties have been imposed. It in fact appears that the court is not aware or is not following the laws that require an approval of the treatment when U.R. has not been properly followed. I have also reported the employer/insurance company many times to the Medical Unit including indexed proof of the failures. The Medical unit has not taken any action and has been totally unhelpful.

So it is imperative that actions not be taken which add more burden to the injured worker and his/her medical providers. More and more physicians are reluctant to accept Workers Compensation patients. and patients -like me- don't feel that we are getting the best or deserved treatment by some doctors who do accept them. Please realize that the doctor is in business and must make a profit. Running injured workers through like sardines should not be the goal. It

doesn't meet the constitutional or labor code laws to provide efficient, effective and prompt medical treatment. Watering down Sandhagen is not helpful to the purpose. Please reconsider that the employers and insurance companies have unlimited resources and are paid a fair and large fee for their services. Adding one more nail in the coffin of the injured worker is not what your agency should be about.

Thank you. Johnella Shackelford Injured California Worker who finds the system already totally stacked against the injured worker

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Rita Bradley, RN September 24, 2010
Anthem Workers' Compensation Dept.

RE: 9785.5. Request for Authorization **Draft DWC Form RFA 092210a**

State of California - Division of Workers' Compensation

Request for Authorization for Medical Treatment (DWC Form RFA)

Must be accompanied by a medical report substantiating the requested treatment: the Doctor's First Report of Occupational Injury or Illness (Form DLSR 5021), a Treating Physician's Progress Report (DWC Form PR-2), or a narrative report

I have worked UR for almost 10 years. Having seen many MD's requests for treatment in various forms, I have thought that there should be a specific form that should be filled out with the specific requests that the MD is making at this time. Many times there are many "plans" of treatment & it is difficult to ascertain exactly what the physician is requesting

I do have an issue with **Only a single treatment request can be made on this form**

Most surgeries can contain 1-12 requests on them. I think that there should be comment stating that the requests must be specific & attached to the MD report, using this sheet as a cover sheet.

Since many insurance companies are over-compensating for MD requests since they do not want any penalties, this has impacted the UR process.

I applaud the concept that the MD's should have a standardized form to submit & that is the day of the request received by claims to start the process. I believe that claims should be able to return these flimsy reports back to the MD with the request that they SPECIFY what they have to request in the treatment plan for the IW.

Robert Gonzales September 24, 2010

While the proposed Request for Authorization form will certainly make it easier for review, unfortunately the time that will be required to fill out the form is going to really tax already overwhelmed treating physicians. The most important objective is having injured workers provided with timely, reasonable and indicated care. Why is it necessary to require the patient's date of birth, date of injury and employer on the form? Shouldn't the patient's name and claim number be sufficient? Likewise, under "Physician Information," why isn't the physician's name sufficient for the purpose of having the recommended treatment considered, especially when a copy of a report is attached? Similarly, in regard to "Claims Administrator Information," it would seem that the name of the adjuster and the adjuster's fax number would be sufficient for UR purposes. The biggest obstacle to timely treatment, particularly in non-State Compensation Insurance Fund cases is that insufficient information (reports) are provided to the medical review physician. Quite often there are prior (QME, AME, PQME and PTP) reports which the reviewing physician needs to review in order to make a timely, intelligent decision. Usually, the adjuster simply passes the PTP's recommendation to UR without this necessary, supporting documentation even though the adjuster knows that the PTP's recommendations are being made pursuant to prior AME, PQME, PTP, etc.'s recommendation or prior peer to peer agreements. Who should be responsible for providing this information initially to UR: the busy doctor's office or the busy adjuster? Where this occurs, the UR process can delay needed care for months or for a year or longer. Most often (in non-State Comp cases) the medical reviewer on the fifth business day after receipt of the request for authorization will simply recommend denial of the requested care because of the lack of information. Almost never does a UR medical reviewer request the needed information and then wait until on or about the 14th day after receipt of the initial request to issue a recommendation

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Ruth L. S. Miller September 23, 2010

Why more paper work? Once an injured worker has a permanent disability and is rated as 100%, he/she should NOT have to go through the UR/QME process for continued treatment or supplies. If a rating of 100% is granted, and the physician orders and documents the medical necessity the injured worker rated as 100% really needs treatment. Please include the exemption from the UR/QME process and filing out the proposed form for those who are PD rated as 100%.